Although the JP is the primary means of extraction from the swamp, cross training on the SKEDCO litter is essential for cases involving a back or neck injury. During 6th RTB's most recent training, the flight medic was pre-positioned at the extraction location on the ground where he was able to conduct training on the actual terrain where a hoist mission is most likely to become necessary.

We learned several lessons from this training:

First, a SKEDCO should not be used when extracting a casualty from the swamp if a JP will suffice. The dense vegetation of the swamps made it very difficult to find an area large enough to use the SKEDCO. Cable awareness is paramount, especially in night operations. The cable can easily become entangled with the ground team and cause serious injury. Signals should be made by only one signalman; more than one creates too much confusion and can be dangerous. Rigging a patient for a SKEDCO hoist while under the rotor wash is detrimental to both ground personnel and air crew. Once the necessary equipment is lowered, signal the aircraft off into an orbit, and have the flight medic call the aircraft back overhead once he is ready to extract. Safety goggles and a kevlar helmet help protect the ground crew and the patient from dead-fall blown down by the rotor wash.

Through constant training and evaluation, MEDEVAC training has paid big dividends for our soldiers. Our Ranger Instructors are now more proficient in MEDEVAC operations, which has translated into better MEDEVAC training for the Ranger students as well. It has also provided the Florida Phase of Ranger School with a stronger safety net in the event we do encounter injuries that threaten life, limb, or eyesight. By dedicating effort and enthusiasm to our MEDEVAC training, we have developed—and continually revalidate—techniques that ensure better, safer, and more realistic training for the Ranger students and cadre of the 6th Ranger Training Brigade.

Captain Marc Cloutier, when he wrote this article, was S-3 Air of the 6th Ranger Training Battalion, at Eglin Air Force Base, Florida.

Integrating Medical Training
Into Company Warfighting Training

CAPTAIN LAWRENCE O. BASHA

When an infantry officer takes command of a company, he wants to make it the best fighting force possible. Many of us know how to develop the maneuver aspects of training, but we may not be sure how to improve other areas that support the company's ability to fight.

One essential support skill is the ability of trained combat life savers (CLSs) to perform medical tasks. The training and evaluation of medical personnel is the responsibility of the battalion medical officer. The company commander, in turn, can use the medics to train and evaluate his infantry personnel. This article provides suggestions on how the company commander can improve soldiers' CLS skills.

Any good infantry commander knows the value of correct and timely first aid on the battlefield. The Bellamy Analysis of casualties in World War II, Korea, and Vietnam—a major, comprehensive study of wound effects—found that 80 percent of combat deaths occurred in the first hour after injury. Of these casualties, 50 percent bled to death, half of whom could have survived if the bleeding had been stopped. Saving lives is the fundamental reward from a good medical training program.

Improving life-saving skills yields other benefits as well. An individual soldier gains confidence when he can perform the actions that he knows will save lives, and when he has truly mastered a skill he can use anywhere and any time. Units gain confidence going into battle, knowing that they will be cared for by the soldiers around them. Soldiers will fight harder when they know there is good, competent care and an evacuation program to take the wounded back to a dedicated care giver. These are not easily quantifiable benefits, but they are important and a good commander will work to improve them.

Ranger CLS Training: A Case Study

The results of a good CLS program are impressive. Recently, I observed a platoon raid conducted by 3d Battalion, 75th Ranger Regiment. A fire team was providing security in an intermediate support-by-fire position. A medical observer-controller (OC) came up from behind and assessed a casualty on the fire team—a Ranger was given a shoulder wound. The OC put a laminated index card specifying the injury on a 550-cord loop around the Ranger's neck. The combat life saver with the CLS bag went to his aid. He prepared the injured Ranger and applied the proper bandages. Without looking up,

he asked the medical OC, "Has the bleeding stopped?" The OC told him that it had, and the Ranger CLS continued to stabilize the bandages and prepare the Ranger for evacuation. "Is the patient conscious?" asked the Ranger. The OC told him yes, but the soldier could not assist him, nor could he walk. This said, the Ranger began to prepare this casualty for movement. The medical OC moved on to assess another casualty. The CLS then moved the first casualty to the platoon casualty collection point (CCP) and helped evacuate him to the battalion aid station (BAS).

To the casual observer, this may seem like a very high-speed process, but when examined, it is the result of four basic training principles:

- The 3d Battalion, 75th Ranger Regiment, uses dedicated medical OCs to evaluate and influence the medical training during blank fire exercises (BFXs) and live fire exercises (LFXs). These OCs assess specific casualties on the force.
- The OC evaluates the care given to the casualties.
- All the Rangers go through CLS training when they arrive at the unit.
- The Rangers have regular medical and CLS refresher training.

It is because of command emphasis and continual training that the 3d Battalion, 75th Ranger Regiment's CLS training program sets the standard and is hence worthy of emulation.

The inclusion of casualty play during an LFX or a BFX puts individual training into perspective and enhances the overall mission training. A typical training evaluation consists of a medical OC who is equipped to assess casualties and is responsible for providing medical coverage for the range. He carries casualty tags (similar to the MILES casualty cards) on 550-cord loops so that when a casualty is designated, the injury and the patient's condition are easily visible to caregivers. The casualty wears this around his neck and does not have to hold it or dig it out of a pocket when a new caregiver comes to him.

When the OC assesses an injury, he observes the treatment until he feels satisfied with it and then moves on to the next casualty. The Rangers then evacuate the casualty to the next higher level of care (platoon to company, company to battalion).

Following the exercise, a medical-specific AAR is conducted, and the comments are plugged into the training management cycle. Through this training sequence, the battalion has improved the individual Rangers' medical ability and increased the unit's combat effectiveness and survivability.

Command Emphasis. For the infantry company commander, improving the company's medical treatment is not difficult. Command emphasis on the training program is essential, and this can be achieved in numerous ways.

Commanders can schedule time on the training calendar for the initial and refresher training. They can make sure personnel attend the classes and emphasize 100 percent attendance. Units should develop CLS training kits containing the bandages and other items required for training. Resources for training may include new or improvised supplies (such as cravats made out of fabric). These can be stored in used ammunition boxes or containers from the Defense Reutilization and Marketing Office, thus saving unit funds. The commander should ensure that appropriate medical supplies are available for training missions and make it a policy that he be notified when items are missing and cannot be replaced. Finally, the commander can require that casualty play be integrated into all maneuver exercises, no matter what size element is being trained.

The inclusion of casualty play during an LFX or a BFX puts individual training into perspective and enhances the overall mission training.

Initial Training. The commander can schedule annual CLS training to be conducted three or four times a quarter, so the entire company can be trained one quarter at a time. Personnel who cannot attend one session should be able to get into another. Although some of the company's soldiers may not achieve qualification, the commander should closely monitor training to keep this number to a minimum, below 10 percent if possible. Sending personnel to other courses on the installation may also reduce the number of unqualified soldiers. This may be an inconvenience to some, but it will clearly demonstrate command emphasis. The object is to see that all personnel are CLS certified. Since each course can be run for about one-third of the company, sessions can be scheduled around prime training times.

The CLS course itself should focus on trauma. The instructors should emphasize the type of trauma the company would see in combat, such as gunshot wounds. Explaining what the CLS can expect in a real-life situation will focus the soldiers on the course. Subjects to be emphasized should include trauma care, tactical field care, and casualty evacuation. Since this course will be geared for one company, instructors can cover company SOPs and teach everyone the proper techniques and procedures for CLS treatment, evacuation procedures, and the CCP setup.

Sustainment Training. Following the initial training, the company can have medical classes en masse or for a sub-element (platoon, squad, fire team, or two or three individuals). The classes can be conducted in a formal classroom setting or in the field. They should combine instruction and practical application. The smaller the number of soldiers trained at one time, the greater the value of the training, and the less time the soldiers waste waiting for evaluation.

Since many of our leaders and soldiers have never been in combat and do not know first-hand what to expect, the commander can have a former combat veteran give a talk to the unit about what types of injuries he has seen in battle. The 3d Battalion, 75th Ranger Regiment, has had good results with this type of briefing. It adds emphasis to the medical training and gives the men a better idea of what to expect. It also gives the medical personnel and the 11-series CLS ideas for setting up the training for the upcoming medical refresher training.

Trauma Lanes. Trauma lanes are simply a means of hands-on evaluation for the CLS, allowing him to practice and be evaluated on his skills. These lanes can be as simple or as complex as the trainer desires. The most basic trauma lane consists of one evaluator, one casualty, and one CLS trainee in a static location with minimal medical resources. This can be expanded as far as the trainer's imagination and resources will allow. An important aspect of the training is an evaluator who can both teach and evaluate the CLS. Together, the platoon medic and the battalion aid station (BAS) personnel can determine the focus of the trauma lane (blunt trauma, evacuation, broken bones).

The duration of training can also be varied. Individual CLS can treat single or multiple injuries. Additionally, the duration of tasks may be increased by having the CLS conduct a sequence of treatments. Since this training and evaluation is a one-on-one process, training in smaller elements reduces the time soldiers wait for instruction and practical application. An iteration will usually take about as long as most complex EIB or NBC station tasks.

The location of the trauma lane can also be adjusted. The basic trauma lane can be conducted in a day room or the company area. Obviously, the trauma lane would be more complex and difficult in a training area or on a range (for example, by conducting the basic trauma lane on a qualification or static range). The platoon or company medic who covers the range can act as the evaluator. If a medical emergency arises, the medic can react without delay.

As with all skills, some soldiers develop better competencies more quickly than others. These soldiers should be identified and given the responsibility of being the CLS for the fire team or squad. All soldiers should undergo CLS training, but the more adept ones should be designated primary CLS for the unit. Once these soldiers have had some experience as primary CLSs, they should be rotated out so that another soldier can benefit from the responsibility of the position.

CLS Equipment Bags. One of the pre-combat inspections (PCIs) should be to check and restock the CLS bags. This inspection should be supervised by the company senior medic or a representative from the BAS. This gives the CLS the responsibility for maintaining "his" equipment. Having the senior medical personnel supervise the PCI increases the interoperability of the chain of medical care and treatment. It gives the senior medical personnel another opportunity to mentor and train the CLS. This increases the unit's medical capability and confidence.

Medical Rehearsals. Another important step is to have medical rehearsals on ranges before training. These rehearsals should incorporate the expected type of injuries, the anticipated level of care, and the evacuation procedures. A BFX will be different from an LFX or a static fire range. The rehearsal should incorporate as many CLSs and dedicated medical personnel as possible. Once again, this gives soldiers a sense of ownership and makes them more eager to participate.

Casualty Play. A key to improving medical training is the integration of casualty play in BFX and LFX training. This gives soldiers the closest idea of what they can expect during combat and the opportunity to use their CLS training in the proper sequence when they have finished their primary infantry tasks. The company should designate a member of the BAS as a medical OC. This requires that the commander make full use of the BAS personnel. The commander should outline and supervise the medical personnel's preparation for training and evaluation. Their preparation should include the use of moulage kits for casualties (OPFOR during blank fire), a detailed list of injuries they plan to assess on the soldiers, the standard by which they will evaluate the care and evaluation process, the proper means of identifying casualties, and the specifics for the AAR.

The medical personnel will be responsible for the preparation and evaluation for the exercise, but the commander must supervise the process to tailor it to his goals for the company. Checking the types of injuries planned will eliminate irrelevant and distracting training. Ensuring that casualties are marked by an easily identifiable information card will eliminate any confusion about the injury, and keep a soldier from forgetting that he has an injury and getting up to go back to the fight. The medical briefback on the evaluation process and the AAR will provide a better working relationship with the medical support personnel and allow the commander to ensure that training is conducted in accordance with his intent.

Post-exercise Assessment. The medical training continues after the exercise has ended. The Medical AAR should be sequenced to follow the unit AAR and cover the standard AAR format. This will lead to improvements in individual skills and the company's medical SOPs and give the CLSs feedback in the environment where they will be expected to perform. No commander would think of conducting an exercise without having a unit AAR afterward. The infantry commander should give feedback to the medical personnel about their integration with the unit, including comments—to sustain and improve performance—about the exercise casualty play, the OCs' conduct, and the evaluation process. This feedback will help the BAS personnel improve their own systems for supporting the unit in combat.

These are some tried and true methods for improving the infantry company's ability to provide aid on the battlefield. Improving the company's CLS program will result in the most important reward for the commander: saving soldiers' lives. In addition, helping individual soldiers and their units gain confidence and skills in life-saving will have benefits that extend far beyond just putting the bandages in the right places.

Captain Lawrence O. Basha served in the 3d Battalion, 75th Ranger Regiment, at Fort Benning, and as a senior engineer sergeant in a Special Forces detachment. He is a 1988 graduate of the University of New Mexico and was commissioned through the Officer Candidate School in 1995.